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| TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: HEALTH CARE FINANCING ADMINISTRATION | 1. TRANSMITTAL NUMBER: <u>9 6 - 0 0 3</u> | 2. STATE: MA |
| | 3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID) Title XIX | |
| TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES | 4. PROPOSED EFFECTIVE DATE 1/1/96 | |

5. TYPE OF PLAN MATERIAL (Check One):

- ☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

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|---|---|
| 6. FEDERAL STATUTE/REGULATION CITATION: 42 CFR 435.232 | 7. FEDERAL BUDGET IMPACT: a. FFY _____ \$ _____ b. FFY _____ \$ _____ |
| 8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Supplement 6 to Attachment 2.6-A and Page 4 of Attachment 2.6-A | 9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Same |

10. SUBJECT OF AMENDMENT:

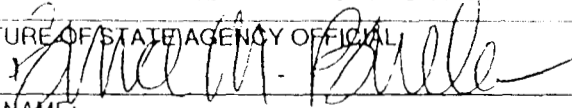
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
State Supplementary Income Levels

11. GOVERNOR'S REVIEW (Check One):

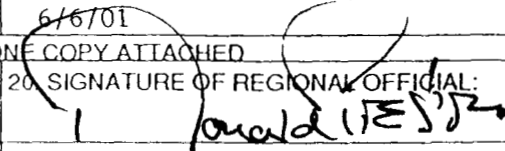
- ☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

☒ OTHER, AS SPECIFIED:

Not Required under 42 CFR 430.12 (b) (2)(

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| 12. SIGNATURE OF STATE AGENCY OFFICIAL:  | 16. RETURN TO: Bridget Landers Coordinator, State Plan 600 Washington Street, 3rd Floor Boston, MA 02111 |
| 13. TYPED NAME: Bruce M. Bullen | |
| 14. TITLE: Commissioner, Division of Medical Assistance | |
| 15. DATE SUBMITTED: xxxxxxx 3/29/96 | |

FOR REGIONAL OFFICE USE ONLY

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| 17. DATE RECEIVED: 3/29/96 | 18. DATE APPROVED: 6/6/01 |
| 19. EFFECTIVE DATE OF APPROVED MATERIAL: 1/1/96 | |
| 20. SIGNATURE OF REGIONAL OFFICIAL:  | 21. TYPED NAME: Ronald Preston |
| 22. TITLE: Associate Regional Administrator Division of Medicaid and State Operations | |
| 23. REMARKS: | |

| Citation | Condition or Requirement | | | | | | | | | | | | | | | | |
|-------------------------------|--|-------------|-------|---------|--------|----------|-------|--------|-------|-----------|----|-----------|----|-----------------------|----|------------------|--|
| 435.725 435.733 435.832 | <p>B. <u>Post-Eligibility Treatment of Institutionalized Individuals</u></p> <p>The following amounts are deducted from gross income when computing the application of an individual's or couple's income to the cost of institutional care:</p> <p>1. Personal Needs Allowance.</p> <p>a. Aged, blind, disabled--</p> <table><tr><td>Individuals</td><td>\$ 60</td></tr><tr><td>Couples</td><td>\$ 120</td></tr></table> <p>* The personal needs allowance for SSI recipients in nursing facilities and chronic disease hospitals is \$65 per month</p> <p>* For the following individuals with greater need-- Amount paid to veteran pursuant to Section 8003, not in excess of \$90 per month</p> <p>b. AFDC related--</p> <table><tr><td>Children</td><td>\$ 60</td></tr><tr><td>Adults</td><td>\$ 60</td></tr></table> <p>c. Individuals under age 21 covered in this plan as specified in Item B.7. of <u>ATTACHMENT 2.2-A</u>.</p> <p>\$60.00</p> <p>2. For maintenance of the non-institutionalized spouse only. The amount must be based on a reasonable assessment of need but must not exceed the highest of --</p> <table><tr><td>SSI level</td><td>\$</td></tr><tr><td>SSP level</td><td>\$</td></tr><tr><td>Medically needy level</td><td>\$</td></tr><tr><td>Other as follows</td><td>\$ 1918.50 per provisions of Section 1924(d) of the Act</td></tr></table> | Individuals | \$ 60 | Couples | \$ 120 | Children | \$ 60 | Adults | \$ 60 | SSI level | \$ | SSP level | \$ | Medically needy level | \$ | Other as follows | \$ 1918.50 per provisions of Section 1924(d) of the Act |
| Individuals | \$ 60 | | | | | | | | | | | | | | | | |
| Couples | \$ 120 | | | | | | | | | | | | | | | | |
| Children | \$ 60 | | | | | | | | | | | | | | | | |
| Adults | \$ 60 | | | | | | | | | | | | | | | | |
| SSI level | \$ | | | | | | | | | | | | | | | | |
| SSP level | \$ | | | | | | | | | | | | | | | | |
| Medically needy level | \$ | | | | | | | | | | | | | | | | |
| Other as follows | \$ 1918.50 per provisions of Section 1924(d) of the Act | | | | | | | | | | | | | | | | |

HCFA No. 96-03
Supersedes
HCFA No. 95-16

Approval Date 06-06-01

Effective Date 1/1/96

HCFA ID: 7985E

STATE: MASSACHUSETTS

Standards for Optional State Supplementary

| PAYMENT CATEGORY | ADMINISTERED BY | | INCOME LEVEL | | | | INCOME DISREGARD |
|------------------------------|-----------------|--------|--------------|---------|------------|--------|--|
| (1) | (2) | | (3) | | (4) | | (5) |
| Reasonable Classification | Federal | State | Gross | | Net | | |
| AGED | INDIVIDUAL | | INDIVIDUAL | COUPLE | INDIVIDUAL | COUPLE | DISREGARD |
| Full Cost Of Living Expenses | 470.00 | 126.32 | 1277.64 | 1888.44 | 596.32 | 901.72 | First \$20. unearned income* First \$65 earned income and 1/2 remaining earned income |
| Shared Living Expenses | 470.00 | 36.76 | 1098.52 | 1888.44 | 506.76 | 901.72 | |
| Household Of Another | 313.34 | 101.86 | 915.40 | 1446.60 | 415.20 | 680.80 | |
| Rest Home | 470.00 | 293.00 | 1611.00 | ----- | 763.00 | ----- | |
| Nursing Facility | 30.00 | 35.00 | 215.00 | 345.00 | 65.00 | 130.00 | |
| DISABLED | INDIVIDUAL | | INDIVIDUAL | COUPLE | INDIVIDUAL | COUPLE | |
| Full Cost Of Living Expenses | 470.00 | 111.89 | 1248.78 | 1845.12 | 581.89 | 880.06 | |
| Shared Living Expenses | 470.00 | 27.90 | 1040.80 | 1845.12 | 497.90 | 880.06 | |
| Household Of Another | 313.34 | 85.08 | 881.84 | 1403.36 | 398.42 | 659.18 | |
| Rest Home | 470.00 | 293.00 | 1611.00 | ----- | 763.00 | ----- | |
| Nursing Facility | 30.00 | 35.00 | 215.00 | 345.00 | 65.00 | 130.00 | |

* If no unearned income, or less than \$20.00 this is deducted from earned income.
For Title XIX purposes, the limit is subject to the 300% cap, or \$1,410.00.

TN No. 96-03
Supersedes
TN No. 95-05

Approval Date 06-06-01

Effective Date: 01/01/96